		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045427

Facility Name: St Joseph Home of Chicago

Address: 2650 North Ridgeway Avenue (Number) Chicago (City) 60647 (Zip Code)

County: Cook

Telephone Number: 773-235-8600 **Fax #** 773-235-2933

HFS ID Number: 351124441003

Date of Initial License for Current Owners: 06/03/59

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Eliseo Sotelo **Telephone Number:** 773-235-8600 x 107

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/04 to 06/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Michael Barth
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	173	Skilled (SNF)	109	39,785	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	173	TOTALS	109	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,194	46	2,337	6,577	8
9	SNF/PED					9
10	ICF	18,069	9,687		27,756	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,263	9,733	2,337	34,333	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.30%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/03/09

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided _____

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/05 Fiscal Year: 06/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Joseph Home of Chicago # 0045427 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	312,099	302		312,401	5,320	317,721		317,721			1
2	Food Purchase		265,971		265,971		265,971		265,971			2
3	Housekeeping	185,220	19,974		205,194		205,194		205,194			3
4	Laundry	73,132	12,011		85,143		85,143		85,143			4
5	Heat and Other Utilities			173,429	173,429		173,429		173,429			5
6	Maintenance	137,590	7,538	44,349	189,477		189,477		189,477			6
7	Other (specify):* Security & Waste			79,747	79,747		79,747		79,747			7
8	**TOTAL General Services**	708,041	305,796	297,525	1,311,362	5,320	1,316,682		1,316,682			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,466,110	216,969	5,917	2,688,996	3,160	2,692,156		2,692,156			10
10a	Therapy			175,643	175,643		175,643		175,643			10a
11	Activities	124,575	4,772	13,927	143,274	574	143,848		143,848			11
12	Social Services	58,032	4		58,036		58,036		58,036			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,648,717	221,745	202,687	3,073,149	3,734	3,076,883		3,076,883			16
	C. General Administration											
17	Administrative	149,256		318,042	467,298		467,298	(67,091)	400,207			17
18	Directors Fees											18
19	Professional Services			59,935	59,935	(9,054)	50,881		50,881			19
20	Dues, Fees, Subscriptions & Promotions			21,239	21,239		21,239	(2,934)	18,305			20
21	Clerical & General Office Expenses	391,202	15,800	34,905	441,907		441,907		441,907			21
22	Employee Benefits & Payroll Taxes			1,074,828	1,074,828		1,074,828		1,074,828			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,456	11,456		11,456		11,456			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			119,987	119,987		119,987		119,987			26
27	Other (specify):*											27
28	**TOTAL General Administration**	540,458	15,800	1,640,392	2,196,650	(9,054)	2,187,596	(70,025)	2,117,571			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,897,216	543,341	2,140,604	6,581,161		6,581,161	(70,025)	6,511,136			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Joseph Home of Chicago #0045427 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			200,369	200,369		200,369		200,369			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,338	35,338		35,338		35,338			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			235,707	235,707		235,707		235,707			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			3,380	3,380		3,380		3,380			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,686	78,686		78,686		78,686			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			82,066	82,066		82,066		82,066			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,897,216	543,341	2,458,377	6,898,934		6,898,934	(70,025)	6,828,909			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	21,930	17-3		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	45,161	17-3		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	2,934	20-7		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 70,025		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 70,025		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Addolorata Villa	Wheeling, IL	FSCSC	Homewood, IL	Religious Mgmt.
		Marian Village	Homer-Glen, IL			
		St James Manor	Crete, IL			
		Franciscan Village	Lemont, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17-3	Information Technology	$ 144,000	Franciscan Sisters of Chicago Service Corp		$ 144,000	$	1
2	V		17-3	Administrative, religious srv	98,484	Franciscan Sisters of Chicago Service Corp		98,484		2
3	V		17-3	Mkt-intercompany expenses	7,917	Franciscan Sisters of Chicago Service Corp		7,917		3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 250,401			$ 250,401	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17-3	Information Technology	% of bed units	2,194	11	$ 1,890,000	$ 1,890,000	173	$ 149,029	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,890,000	$ 1,890,000		$ 149,029	25

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number St Joseph Home of Chicago **#** 0045427 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000		8
	2001		9
	2002		10
	2003		11
	2004		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Joseph Home of Chicago COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045427

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 94,171 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	94,171	1928	$ 12,325	1
2	Future site	196,020	2003	290,802	2
3	TOTALS	290,191		$ 303,127	3

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	173		1929	1929	$ 377,812	$		$	$	$ 377,812	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9				1954	10,227		26			10,227	9
10				1955	5,952		25			5,952	10
11				1956	4,509		24			4,509	11
12				1958	14,846		41			14,846	12
13				1959	17,042		40			17,042	13
14				1963	35,827		20			35,827	14
15				1964	64,840		20			64,840	15
16				1966	59,466		20			59,466	16
17				1967	223,218		20			223,218	17
18				1968	237,183		20			237,183	18
19				1973	182,118		20			182,118	19
20				1974	231,457		20			231,457	20
21				1976	162,056		20			162,056	21
22				1977	1,136,934		20			1,136,934	22
23				1978	470		20			470	23
24				1982	9,434		10			9,434	24
25				1983	1,297,652		20			1,297,652	25
26				1984	409,810		15			409,810	26
27				1985	216,977		20			216,977	27
28				1986	6,710		10			6,710	28
29				1987	15,790		10			15,790	29
30				1988	66,942		20			66,942	30
31				1989	3,134		10			3,134	31
32				1990	273,817	2,916	20	2,916		273,817	32
33				1991	154,978	10,332	15	10,332		144,645	33
34	Employee Café/Fire alarm			1992	2,264	151	15	151		1,887	34
35	Employee Café/Fire alarm			1992	5,839	292	20	292		3,650	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Emergency generator installation	1992	$ 83,803	$ 5,587	15	$ 5,587	$	$ 64,249	37
38	Dumb water repair	1992	2,346		10			2,346	38
39	Hot & cold water pressure tank	1992	35,760	1,788	20	1,788		20,622	39
40		1993	49,024	3,268	15	3,268		37,585	40
41	Completion of trayline	Aug-94	47,708	3,181	15	3,181		33,396	41
42	Credit for trayline	Aug-94	(4,543)	(303)	15	(303)		(3,180)	42
43	Concrete & tuckpointing Nr.North	Sep-94	4,250	425	10	425		4,250	43
44	Install electric trayline	Sep-94	2,475	165	15	165		1,733	44
45	SJH Building Title insurance	Sep-94	9,027	451	20	451		4,739	45
46	Telephone system equipment	Oct-94	6,499	650	10	650		6,499	46
47	Emergency generator consultation	Jan-95	4,850	323	15	323		3,395	47
48	Chimney repair	Apr-95	618	41	15	41		433	48
49	Chimney repair	Jun-95	120	8	15	8		84	49
50	Masonry repair project	Jun-95	3,300	132	25	132		1,386	50
51	Fire alarm update	Jul-95	2,630	263	10	263		2,499	51
52	Roofing	Jul-95	2,300	92	25	92		874	52
53	Masonry repair project	Oct-95	2,980	119	25	119		1,132	53
54	500 gallon tank system	Nov-95	21,118	845	25	845		8,025	54
55	Networking cabling	Dec-95	3,000	300	10	300		2,850	55
56	New pipes and padding	Dec-95	9,875	395	25	395		3,753	56
57	Entrance canopy 3rd floor deck	Jan-96	9,876	988	10	988		9,382	57
58	Emergency back-up generator	Jan-96	173,754	8,688	20	8,688		82,533	58
59	Temperature controls	Sep-96	1,552	155	10	155		1,319	59
60	Outside of building masonry	Sep-96	41,500	1,660	25	1,660		14,110	60
61	Electrical wirings	Nov-96	789	39	20	39		335	61
62	Outside of building masonry	Dec-96	36,396	2,426	15	2,426		20,624	62
63	Outside of building masonry	Jan-97	44,100	2,940	15	2,940		24,990	63
64	Outside of building masonry	Jan-97	30,420	2,028	15	2,028		17,238	64
65	Outside of building masonry	Jan-97	73,980	4,932	15	4,932		41,922	65
66	Outside of building masonry	Jan-97	59,202	3,947	15	3,947		33,547	66
67	Ward masonry & repairs	Aug-97	100,260	6,684	15	6,684		50,130	67
68	Ward masonry & repairs	Sep-97	70,650	4,710	15	4,710		35,325	68
69	1st floor renovation	Oct-97	9,458	631	15	631		4,729	69
70	TOTAL (lines 4 thru 69)		$ 6,166,381	$ 71,249		$ 71,249	$	$ 5,747,258	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,166,381	$ 71,249		$ 71,249	$	$ 5,747,258	1
2	1st floor renovation	Nov-97	70,229	4,682	15	4,682		35,114	2
3	Wiring & lighting system	Nov-97	3,954	395	10	395		2,966	3
4	Audio cable wall jacks	Nov-97	295	20	15	20		148	4
5	Door hardware & locks	Nov-97	522	35	15	35		261	5
6	Phase I window treatment	Nov-97	10,755	1,075	15	1,075		8,066	6
7	1st floor renovation	Dec-97	75,552	5,037	10	5,037		37,776	7
8	Ward masonry repairs	Dec-97	60,519	4,035	15	4,035		30,259	8
9	2nd floor asbestos removal	Jan-98	5,810	387	15	387		2,905	9
10	Metal & roofing work	Jan-98	12,520	835	15	835		6,260	10
11	Curtains & mini blinds, cafeteria blinds	Feb-98	8,212	411	20	411		3,079	11
12	electrical wiring & lighting system	Feb-98	12,349	1,235	10	1,235		9,262	12
13	data cabling	Feb-98	3,919	261	15	261		1,960	13
14	electrical wiring & lighting system	Feb-98	1,636	164	10	164		1,227	14
15	1st floor painting & floor covering	Mar-98	10,070	671	15	671		5,035	15
16	Install privacy curtains	Mar-98	5,870	293	20	293		2,201	16
17	Door hardware & locks	Mar-98	11,248	750	15	750		5,624	17
18	Install privacy curtains	Apr-98	1,996	100	20	100		748	18
19	1st floor remodeling phase II	Apr-98	92,508	9,251	10	9,251		69,381	19
20	Signage phase I & II	Apr-98	1,203	80	15	80		602	20
21	Telephone update	Apr-98	227	15	15	15		113	21
22	Lighting fixtures	Apr-98	146	15	10	15		110	22
23	Masonry repairs	May-98	71,682	4,779	15	4,779		35,841	23
24	Phase II window treatment	May-98	3,598	360	10	360		2,698	24
25	1st floor remodeling phase II	May-98	90,688	6,046	15	6,046		45,344	25
26	Remove asbestos tiles	Jun-98	13,056	870	15	870		6,528	26
27	Install privacy curtains for residents	Jun-98	5,376	269	20	269		2,016	27
28	Signage	Jun-98	2,856	190	15	190		1,428	28
29	Install privacy curtains for residents	Jul-98	2,508	125	20	125		815	29
30	Install fence	Jul-98	2,055	137	15	137		891	30
31	Signage	Jul-98	1,390	93	15	93		602	31
32	Lighting system	Aug-98	526	53	10	53		342	32
33	Flame retardant window treatment	Sep-98	5,531	553	10	553		3,595	33
34	TOTAL (lines 1 thru 33)		$ 6,755,187	$ 114,471		$ 114,471	$	$ 6,070,456	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,755,187	$ 114,471		$ 114,471	$	$ 6,070,456	1
2	1st floor remodeling	Sep-98	61,819	4,121	15	4,121		26,788	2
3	electrical wiring & lighting	Oct-98	14,806	1,481	10	1,481		9,624	3
4	Ductwork modification	Nov-98	3,228	323	10	323		2,098	4
5	Fireproof elevator, Mec rm. Gen. & Boiler	Dec-98	5,800	580	10	580		3,770	5
6	new water treatment	Dec-98	3,792	379	10	379		2,465	6
7	Pull switch & nightlights	Jan-99	10,735	1,074	10	1,074		6,978	7
8	Sewage pump	Jan-99	3,242	324	10	324		2,107	8
9	Replace convent roof	Feb-99	20,000	2,000	10	2,000		13,000	9
10	Lighting fixtures	Mar-99	354	35	10	35		230	10
11	Roof repairs	Mar-99	5,450	545	10	545		3,543	11
12	Sump pump	Mar-99	1,466	147	10	147		953	12
13	Door fire alarm	Apr-99	6,676	668	10	668		4,340	13
14	Garbage compactor	Jul-99	6,337	634	10	634		3,485	14
15	Fire protection survey	Aug-99	900	90	10	90		495	15
16	Magnetic door holders	Oct-99	2,100	210	10	210		1,155	16
17	Boiler repairs	Dec-99	1,432	143	10	143		788	17
18	Replace 2nd & 3rd floor windows	Jan-00	4,700	470	10	470		2,585	18
19	Drapes & blinds	Mar-00	19,066	1,907	10	1,907		10,487	19
20	Replace 2nd & 3rd floor windows	May-00	9,463	946	10	946		5,205	20
21	Replace 2nd & 3rd floor windows	Jun-00	9,443	944	10	944		5,194	21
22	Install wrought iron fence	Aug-00	4,737	316	15	316		1,421	22
23	Install plumbing for 3 tubs	Dec-00	5,200	347	15	347		1,560	23
24	Paint job for 2nd & 3rd floors	Dec-00	3,807	761	5	761		3,426	24
25	Install awnings	Mar-01	3,000	200	15	200		900	25
26	Install chain link fence	May-01	1,831	122	15	122		549	26
27	Install awnings	Jun-01	4,600	307	15	307		1,380	27
28	Paint job for hallways	Jun-01	634	127	5	127		571	28
29	Paving	Jan-72	7,555		8			7,555	29
30	Sidewalks	Jan-74	2,834		15			2,834	30
31	Repaving	Jan-75	3,640		8			3,640	31
32	Blacktop	Jan-79	9,700		8			9,700	32
33	Gate entrance	Jan-86	986		3			986	33
34	TOTAL (lines 1 thru 33)		$ 6,994,520	$ 133,672		$ 133,672	$	$ 6,210,265	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,994,520	$ 133,672		$ 133,672	$	$ 6,210,265	1
2	Tarring & sealcoating	Jan-86	679		8			679	2
3	Concrete	Jan-88	15,525	776	20	776		10,776	3
4	Landscaping	Jan-88	749	75	10	75		300	4
5	Trinity rodding service	Dec-95	9,876	658	15	658		2,634	5
6	Ward contracting	Jan-96	2,980	199	15	199		795	6
7	Land improvement	Jul-97	12,325	822	15	822		3,287	7
8	Sidewalk	Jan-99	4,285	286	15	286		1,143	8
9	Paintjob for hallways	1-Jul	2,393	479	5	479		1,675	9
10	Prog. Digital access control	Aug-01	1,593	159	10	159		558	10
11	Install hot water mix valve	Aug-01	1,305	131	10	131		457	11
12	Install alarm system	Sep-02	5,325	533	10	533		1,864	12
13	Refurbishemployee cafeteria	Oct-02	7,976	532	15	532		1,861	13
14	Bldng tuckpointing	Feb-02	3,600	360	10	360		1,260	14
15	Gas valve for #2 boiler	Mar-02	2,860	191	15	191		667	15
16	Smokestack demolition	Apr-02	45,420	2,271	20	2,271		7,949	16
17	Rebuilt chiller	Aug-02	4,103	274	15	274		684	17
18	Install cantilever gates	Sep-02	325	108	3	108		271	18
19	Demolish balcony North Bldg.	Sep-02	12,974	865	15	865		2,162	19
20	Install awnings N. Bldg door	Sep-02	1,200	80	15	80		200	20
21	Smokestack removal	Nov-02	4,450	223	20	223		556	21
22	Smokestack removal	Dec-02	2,250	113	20	113		281	22
23	Smokestack removal	Jan-03	2,250	113	20	113		281	23
24	Refurbish admittting office wallcovering	Apr-03	684	137	5	137		342	24
25	Signage (downpayment)	Jun-03	350	35	10	35		88	25
26	Install roofing	Jun-03	1,250	125	10	125		313	26
27	Install signage	Aug-03	990	99	10	99		149	27
28	Install airconditioning units	Sep-03	1,404	281	5	281		421	28
29	Relocate sprinkler system	Dec-03	500	20	25	20		30	29
30	Combustion test for boiler 1 & 2	Jan-04	650	43	15	43		65	30
31	Install CO detector for boiler	Jan-04	429	29	15	29		43	31
32	Emergency service generator	Jan-04	662	55	12	55		83	32
33	Clean burners & heat exchanger	Jan-04	320	21	15	21		32	33
34	TOTAL (lines 1 thru 33)		$ 7,146,202	$ 143,765		$ 143,765	$	$ 6,252,168	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,146,202	$ 143,765		$ 143,765	$	$ 6,252,168	1
2	Combustion for boilers 1 & 2	Jan-04	605	40	15	40		61	2
3	Install new radiator for generator	Feb-04	2,611	174	15	174		261	3
4	Repair south elevator cables	Mar-04	14,000	700	20	700		1,050	4
5	Install motor starter for boiler	Mar-04	1,692	113	15	113		169	5
6	Replace water heater	Mar-04	5,237	524	10	524		786	6
7	South elevator load test	May-04	2,500	125	20	125		188	7
8	Belts and batteries for generators	Jun-04	1,219	102	12	102		152	8
9	Install water circulating pump	Jun-05	1,134	38	15	38		38	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,175,200	$ 145,581		$ 145,581	$	$ 6,254,872	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,062,328	$ 56,585	$ 56,585	$		$ 761,991	71
72	Current Year Purchases	8,066	738	738			738	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,070,394	$ 57,323	$ 57,323	$		$ 762,729	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Van-Dodge Ram	1997	Nov-03	$ 3,700	$ 925	$ 925	$	4	$ 1,388	76
77										77
78										78
79										79
80	TOTALS			$ 3,700	$ 925	$ 925	$		$ 1,388	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,552,421	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 203,829	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 203,829	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,018,988	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	construction-new facility	$ 15,683,246	92
93			93
94			94
95		$ 15,683,246	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St Joseph Home of Chicago **#** 0045427 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 15,600	$	1
2	Cash-Patient Deposits	42,814		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	323,758		3
4	Supply Inventory (priced at)	28,080		4
5	Short-Term Investments			5
6	Prepaid Insurance	62,786		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,300,337)		8
9	Other(specify): Cash surrender value	45,793		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (781,506)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	290,802		13
14	Buildings, at Historical Cost	7,175,199		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,074,093		16
17	Accumulated Depreciation (book methods)	(7,018,989)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): construction in progress	15,683,246		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 17,204,350	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 16,422,844	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,516,868	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	62,926		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	457,867		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to third parties	55,517		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,093,178	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,093,178	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 12,329,666	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 16,422,844	$	48

***(See instructions.)**

Facility Name & ID Number St Joseph Home of Chicago **#** 0045427 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,843,513	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,843,513	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,642,224)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	38,275	11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,603,949)	17	
	B. Transfers (Itemize):			
18	**Fund transfer FSCSC**	685,302	18	
19	**Fund transfer -FC communities**	589,705	19	
20	**Fund transfer FC Holding**	9,815,094	20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 11,090,101	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 12,329,665	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,215,270	1
2	Discounts and Allowances for all Levels	(1,713,640)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,501,630	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	443,778	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 443,778	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	5,044	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	27,000	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 32,044	23
	D. Non-Operating Revenue		
24	Contributions	252,551	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 252,551	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Chapel revenue & mass stipends	4,775	28
28a	COBRA & misc items	21,933	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,708	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,256,711	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,316,682	31
32	Health Care	3,076,883	32
33	General Administration	2,187,596	33
	B. Capital Expense		
34	Ownership	235,707	34
	C. Ancillary Expense		
35	Special Cost Centers	3,380	35
36	Provider Participation Fee	78,686	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,898,934	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,642,223)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,642,223)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,663	2,120	$ 78,390	$ 36.98	1
2	Assistant Director of Nursing	1,812	2,032	68,301	33.61	2
3	Registered Nurses	25,788	30,032	764,595	25.46	3
4	Licensed Practical Nurses	17,729	20,035	387,372	19.33	4
5	CNAs & Orderlies	84,358	96,196	1,069,743	11.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,902	2,160	39,404	18.24	9
10	Activity Assistants	5,269	6,342	85,172	13.43	10
11	Social Service Workers	2,333	2,544	58,032	22.81	11
12	Dietician	1,811	2,160	53,303	24.68	12
13	Food Service Supervisor					13
14	Head Cook	1,739	2,037	30,816	15.13	14
15	Cook Helpers/Assistants	19,407	22,115	227,980	10.31	15
16	Dishwashers					16
17	Maintenance Workers	4,924	5,289	84,340	15.95	17
18	Housekeepers	16,104	18,699	185,220	9.91	18
19	Laundry	6,682	7,618	73,132	9.60	19
20	Administrator	1,933	2,890	149,256	51.65	20
21	Assistant Administrator					21
22	Other Administrative	7,020	8,000	229,528	28.69	22
23	Office Manager					23
24	Clerical	13,791	15,718	219,632	13.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,854	2,065	25,720	12.46	31
32	Other Health C: Nur Secretary	1,713	1,913	28,010	14.64	32
33	Other(specify) Compliance/staf	1,462	1,671	39,270	23.50	33
34	TOTAL (lines 1 - 33)	219,294	251,636	$ 3,897,216 *	$ 15.49	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	133	$ 5,320	1-5	35
36	Medical Director	132	7,200	9-3	36
37	Medical Records Consultant	32	3,160	10-5	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1,526	90,967	10a-3	40
41	Occupational Therapy Consultant	1,418	82,521	10a-3	41
42	Respiratory Therapy Consultant	14	2,155	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	15	574	11-5	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,271	$ 191,897		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Richard Bracken			69,418
Michael Barth			79,838
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 149,256

B. Administrative - Other

Description	Amount
Management fee and infor tech fee	$ 242,484
Interco & billing fee, consultting fee	8,467
Charitable donation	21,930
Bad debt expense	45,161
TOTAL (agree to Schedule V, line 17, col. 3)	$ 318,042
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Carlin Associates	nursing consultants	$ 3,160
Quality care consultants	activity consultants	574
Karen Hemzacek	dieatary consultants	5,320
sosin & Lawler	legal	7,542
FR & R	cost report consulting	1,275
Century personnel	recruitment fee	10,000
Ernst & Young	audit fee	21,984
Pro Business	payroll preparation	10,080
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 59,935

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,150
Unemployment Compensation Insurance	88,780
FICA Taxes	293,539
Employee Health Insurance	441,709
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental,Vision & disability	51,562
Retirement benefits 401K match	76,534
Life insurance	33,107
Tuition reimbursement	423
PTO liability	3,174
Employee benefits-other	7,489
Employee lab screening	359
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,074,826

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,551
Advertising: Employee Recruitment	5,528
Health Care Worker Background Check	
(Indicate # of checks performed 3)	(313)
Dues, fees & subscription	7,665
Advertising	5,808
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(2,934)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,305

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
	87
In-State Travel	
	6,288
Seminar Expense	
	5,082
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,457

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Joseph Home of Chicago # 0045427 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LSN-6,641

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? YES If YES, what is the capacity? 109

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 15

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 44,283 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 78,686
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Ernst & Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. Not yet available

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

St Joseph Home of Chicago
Schedule V (Line 7-3)
June 30, 2005

Description	G/L Acct.	Amount
Security Service	80140-553	67,327
Pest Control	80150-555	2,160
Trash Removal	80150-556	10,261
Total		**79,748**

St Joseph Home of Chicago
ScheduleXVII Other Revenue-(Line 24,28 & 28a)
June 30, 2004

Line 28-Chapel Revenue	**G/L Acct.**	**Amount**
Mass stipends and mass donations	45100-053	**4,775**

Line 28a- Misc. Revenue & COBRA

COBRA payment	45100-065	17,364
Purchase Discount	45100-064	2,459
Rummage sale	45100-060	362
Misc.	45100-060	199
Guest meal	45100-060	36
Polling place income	45100-060	305
Gaits, belts pads, copies and uniforms	45100-060	436
Raffle sale	45100-060	95
Rebate	45100-060	677
Total		**21,933**

Line 24 Non-Operating Revenue

Donations	45100-067	**252,551**

St Joseph Home of Chicago
ScheduleXVIII -B.Consultants
June 30, 2005

Description	G/L Acct.	Amount	Hrs Pd
Carlin Associates- medical records	60900-614	3,160	32
Karen Hemzacek-dietary consultan	80040-674	5,320	133
Dr. Mario Salazar- medical director	80050-510	7,200	132
Alliance Rehab-physical therapy sr	70500-502	90,967	1526
Alliance Rehab-occupational therap	70500-503	82,521	1418
Alliance Rehab-speech therapy srv	70500-504	2,155	14
Quality Care Consultants- activity	80020-519	574	15
	Total	**191,897**	**3,271**

Alliance Rehab	15min/unit	PT hrs	OT hrs	ST hrs
Alliance Rehab	Jul-04	173.00	172.00	6.75
Alliance Rehab	Aug-04	113.25	93.00	0.50
Alliance Rehab	Sep-04	100.50	102.25	1.25
Alliance Rehab	Oct-04	97.00	82.75	-
Alliance Rehab	Nov-04	129.75	127.75	2.25
Alliance Rehab	Dec-04	181.50	191.00	-
Alliance Rehab	Jan-05	147.00	146.25	0.50
Alliance Rehab	Feb-05	130.17	126.75	1.00
Alliance Rehab	Mar-05	143.75	125.25	0.77
Alliance Rehab	Apr-05	106.50	95.27	0.50
Alliance Rehab	May-05	63.75	54.50	-
Alliance Rehab	Jun-05	140.00	101.50	0.75
	Total	########	1,418.27	14.27

St Joseph Home of Chicago
ScheduleXIX -B.Administrative -Other
June 30, 2005

Description	G/L Acct.	Amount	
FSCSC- admin religious	80050-675	98,484	
FSCSC- Information technology	80050-690	144,000	
A/R Medicare billing fee	80070-629	551	
Marketing -intercompany expense	80080-684	7,917	
Adm-Charitable donation	80050-480	21,930	
Bad Debt Expense	92250-830	79,801	
Bad debt recoveries	92250-840	(34,639)	67,091 Schedule V, line 17-7 also VI,line 20 & 24
Total		**318,043**	Schedule V, line 17-3

St Joseph Home of Chicago
ScheduleXIX -C.Professional Services
June 30, 2004

Description	G/L Acct.	Amount
		-
Carlin Associates- medical records	60900-614	3,160
Quality Care Consultants- activity	80020-519	574
Karen Hemzacek-dietary consultan	80040-674	5,320
Sosin & Lawler- legal fees	80050-604	7,542
FR & R- cost report consulting	80050-610	1,275
Century personnel-recruitment fee	80050-610	10,000
Ernst & Young- Audit	80070-621	21,984
Pro Business- payroll preparation	80070-570	10,080
Total		**59,935**

Legal Fees - Sosin & Lawler	Invoice #	
	36349	1,265
	35911	429
	36779	270
	36781	331
	37622	184
	37623	1,688
	38084	545
	38085	133
	38511	731
	38953	57
	38954	1,049
	39686	338
	40167	113
	40643	413
	Total	**7,542**

St Joseph Home of Chicago
ScheduleXIX D. Employee Benefits and Payroll Taxes
June 30, 2005

Description	G/L Acct.	Amount
Worker's Compensation	92000-755	78,150
PTO Liability	93000-102	3,174
FICA	93000-201	293,539
Group Health	93000-203	441,709
Group Dental	93000-204	40,759
Group Vision	93000-205	8,390
Group Disability	93000-206	2,413
Retirement benefits	93000-207	76,534
Life Insurance	93000-208	33,107
Unemployment compensation	93000-209	88,780
Tuition reimbursement	93000-210	423
Other employee benefits	93000-211	7,489
Employee lab screening	93000-213	359
	Total	**1,074,828**

St Joseph Home of Chicago
ScheduleXIX F. Dues , Fees Subscriptions & Promotions.
June 30, 2005

Description	G/L Acct.	Amount	
IDPH license fee	80050-707	2,551	
Advertising:Employee Recruitment	80100-648	5,528	
Background check (# ckd.__38___	80050-612	(313)	
Dues and Subscription:			
Fd-dues & subscription	80040-430	225	
Nur-dues	60900-430	663	
Nur- books/reports	60900-431	10	
Act-dues	80020-430	30	
PC-dues	80110-430	14	
Soc-dues	80030-430	-	
Adm-dues	80050-430	6,641	
Adm-books/reports	80050-431	44	
HR dues	80100-430	38	7,665
Advertising & promotion	80080-645	2,874	
Advertising & promotion	80080-646		
Advertising yellow pages	80080-647	2,934	5,808
	Sub Total	**21,239**	
Less: Yellow page advertising		(2,934)	
	Total	**18,305**	

St Joseph Home of Chicago
ScheduleXIX G. Travel & Seminar
June 30, 2005

Description	G/L Acct.	Amount	
A. Out of State Travel			
Adm- mileage of of town	80050-435	87	
B. In State Travel			
	60900-436	508	
	69000-436	753	
	80020-436	114	
	80030-436	47	
	80040-436	82	
	80050-436	712	
	80070-436	576	
	80080-436	844	
	80100-436	127	
	80110-436	403	
	80130-436	50	
	80140-436	2,073	6,288
C. Seminar Expense			
	60900-434	1,301	
	69000-434	525	
	80020-434	60	
	80030-434		
	80040-434	65	
	80050-434	3,081	
	80080-433		
	80110-434		
	80140-434	50	5,082
	Total	**11,456**	